

SCHIP
State Children's
Health Insurance
Program Evaluation

Policymakers appear to be using the flexibility built into Title XXI to manage their SCHIP programs through changing times, cutting or expanding as fiscal conditions permit.

Ebbing and Flowing: Some Gains, Some Losses as SCHIP Responds to Third Year of Budget Pressure

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Heading into 2004, SCHIP recorded its first-ever decline in enrollment. Between June and December 2003, the total number of children in the program nationwide dropped from 3,964,000 to 3,927,000 (Smith, Rousseau, and O'Malley 2004). While it represented just 1 percent of total enrollment, the drop was still a significant turning point, reflecting the cumulative impact of three years of state policy responses to the ongoing economic downturn.

As part of *Assessing the New Federalism's* multiyear SCHIP evaluation, we have been closely tracking how programs and policies have shifted in response to budget pressures. In the latter half of each of the past three years, we conducted in-depth telephone interviews with SCHIP directors in the 13 ANF states—Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. In our first brief, “SCHIP Dodges the First Budget Ax” (Howell, Hill, and Kapustka 2002), we reported that SCHIP programs were largely spared from any serious cuts during 2002's initial budget stress, even as many other programs in state budgets, including Medicaid, were scaled back. The only policy area where states began reducing funding was outreach. When asked why their programs appeared relatively immune from cuts, SCHIP directors told us it was because of the program's efficacy (in reducing the number of uninsured children), small size, high federal match rate, and popularity among policymakers, providers, and consumers.

In 2003, we found that states had begun to cut their SCHIP programs more seriously. In “Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis” (Hill, Stockdale, and Courtot 2004), we reported on such notable changes as the imposition of enrollment caps in 3 of the 13 ANF states, more onerous and restrictive enrollment procedures in 4 states, increased cost sharing in 6 states, reduced benefits in 2 states, reduced provider reimbursements in 5 states, and the virtual elimination of outreach in most states. Still, SCHIP directors reported that their programs fared well compared to other programs. Indeed, several ANF states continued to enhance enrollment procedures and benefits in 2003 even as they cut other parts of their programs.

For 2004, with the national and selected state economies showing signs of a turnaround (NCSL 2004), we have mixed results to report. On the plus side, some states took key actions to reverse previous significant cuts: in particular, enrollment caps were lifted in all three states that imposed them during 2003. At the same time, states kept many prior-year cuts in place, and some states imposed new ones. Overall, there were far fewer cuts to SCHIP in 2004 than in 2003. Policymakers appear to be using the flexibility built into Title XXI to manage their SCHIP programs through changing times, cutting or expanding as fiscal conditions permit. (Characteristics of the ANF states' SCHIP programs, as well as how they correlate with and differ from other states' programs nationwide, appear in box 1.)

Box 1. SCHIP Programs in the ANF States

The 13 states included in the ANF project were selected to provide a diverse, representative sample of states across the nation—geographically, demographically, and economically. However, this sample is somewhat less representative of SCHIP programs. First, the 13 ANF states include the four with the largest SCHIP enrollments—California, Florida, New York, and Texas—as well as the one with the smallest—Minnesota.^a Together, the ANF states account for nearly two-thirds of total SCHIP enrollment (CMS 2004). Second, more ANF states have “separate” SCHIP program components than the nation as a whole—12 of 13 versus 36 of 50. Such programs have considerably more latitude than their Medicaid counterparts to impose enrollment caps, modify benefits packages, and increase cost sharing for enrollees. The ANF states also have slightly higher income eligibility thresholds: in 2003, while the national average upper income threshold for SCHIP was 213 percent of the federal poverty level (FPL), the ANF state average was 227 percent of FPL (based on Urban Institute analysis of state information). Very few states in the nation cover parents of SCHIP enrollees, but three ANF states do—New Jersey, Minnesota, and Wisconsin. Finally, the ANF sample includes two of the three states that were “grandfathered” into the SCHIP program because they offered state-funded children’s health insurance programs before Title XXI was enacted—Florida and New York. Thus, the experiences of the ANF states may not reflect prevailing national experiences with SCHIP over the past year.

Table 1 shows program characteristics and recent enrollment figures for the 13 ANF states.

a. Minnesota had already expanded coverage of children and pregnant women to 275 percent of FPL (under the MinnesotaCare program) before SCHIP passed, and thus covers very few additional children with Title XXI funding. Initially, the state’s SCHIP program only covered children up to age 2 in families with incomes between 275 and 280 percent of FPL. In 2003, Minnesota added coverage of unborn children up to 275 percent of FPL (which includes coverage of prenatal care services for the mother).

How Did SCHIP Programs Change during 2004?

For our third round of interviews, we began by asking SCHIP directors how the budget environment in their states had changed during FY 2004. Next, since virtually every ANF state had enacted program cuts in 2003, we asked directors to discuss any apparent impacts of those cuts on enrollment or access to care. We then explored whether the state legislature had made any further changes in eligibility, enrollment procedures, outreach, benefits, cost sharing, provider reimbursement, and crowd out policies during the most recent legislative session. Finally, we examined whether SCHIP continued to enjoy strong polit-

ical support and whether that support influenced the degree and direction of changes over the past year.

Five of the 13 ANF states reported that their financial situation had improved over the past year, and 4 commented that the climate was still bleak. The remaining 4 reported that conditions had not changed much in 2004. This mixed report seems to generally reflect the national trend. According to the National Conference of State Legislatures, fiscal situations improved at least modestly last year in 47 states (Siegel and Perez 2004). Most states also saw declines in their unemployment rates during 2004 (Bureau of Labor Statistics 2005).

When asked about the effects of 2003’s SCHIP cuts, program directors in Alabama, Colorado, and Florida suggested that their enrollment freezes took a serious toll on children’s coverage—resulting in enrollment drops from 5 to 25 percent. In addition, Texas officials believed that two policy changes—reducing continuous eligibility from 12 months to 6 and implementing a 90-day waiting period for coverage—resulted in an enrollment drop of nearly 30 percent between September 2003 and July 2004.

Table 2 summarizes how the ANF states changed their policies in 2004. The following sections detail these changes.

Eligibility

For 2004, our most significant finding was that all three states that had capped enrollment in 2003—Alabama, Colorado, and Florida—lifted their enrollment caps within a year and began enrolling children in SCHIP again. In the face of severe budget shortfalls, each state had determined it could not sustain enrollment growth and closed enrollment in the second half of 2003. However, state SCHIP directors told us that public and political reactions to the caps were extremely negative, and that legislators entered the 2004 sessions determined to find ways to reverse the policies. While the news that enrollment caps were relatively short-lived is very positive, it is offset by the fact that the freezes seriously affected children’s coverage (figure 1).

Alabama. Alabama’s enrollment cap was officially in place from October 2003 until August 2004. However, state officials maintained a waiting list during the freeze and closely monitored attrition rates. As slots freed up, state officials were able to enroll roughly 2,000 children off the waiting list three times—in November 2003, January 2004, and February 2004. In March 2004, the state legislature fully funded SCHIP for FY 2005, allowing Alabama to transfer all children off the waiting list and enroll all

TABLE 1. Characteristics of SCHIP Programs and Financing in Assessing the New Federalism States

State	Program type	Children enrolled December 2002	Children enrolled December 2003	Change (%)	Financing sources
Alabama	S	55,423	58,696	6	General revenue and tobacco settlement funds
California	C	637,666	722,901	13	General revenue and tobacco settlement funds
Colorado	S	48,500	49,978	3	Designated fund; funded by general revenue and tobacco settlement funds
Florida	C	283,079	319,477	13	General revenue and tobacco settlement funds
Massachusetts	C	56,429	61,968	10	Designated fund; funded by general revenue and cigarette taxes
Michigan	C	47,224	53,767	14	General revenue
Minnesota	C	8	2,731	34,038	Provider taxes
Mississippi	S	53,937	61,159	13	General revenue and tobacco settlement funds
New Jersey	C	93,477	97,940	5	General revenue and tobacco settlement funds
New York	C	513,764	457,317	-11	Provider taxes
Texas	S	500,567	438,164	-12	General revenue and tobacco settlement funds
Washington	S	7,569	9,206	22	Designated fund; funded by provider, liquor, and tobacco taxes, as well as tobacco settlement funds
Wisconsin	M	34,445	37,839	10	General revenue
Total	C: 7 M: 1 S: 5	2,332,088	2,371,143	2	General revenue: 10 Tobacco settlement funds: 8 Other sources: 4

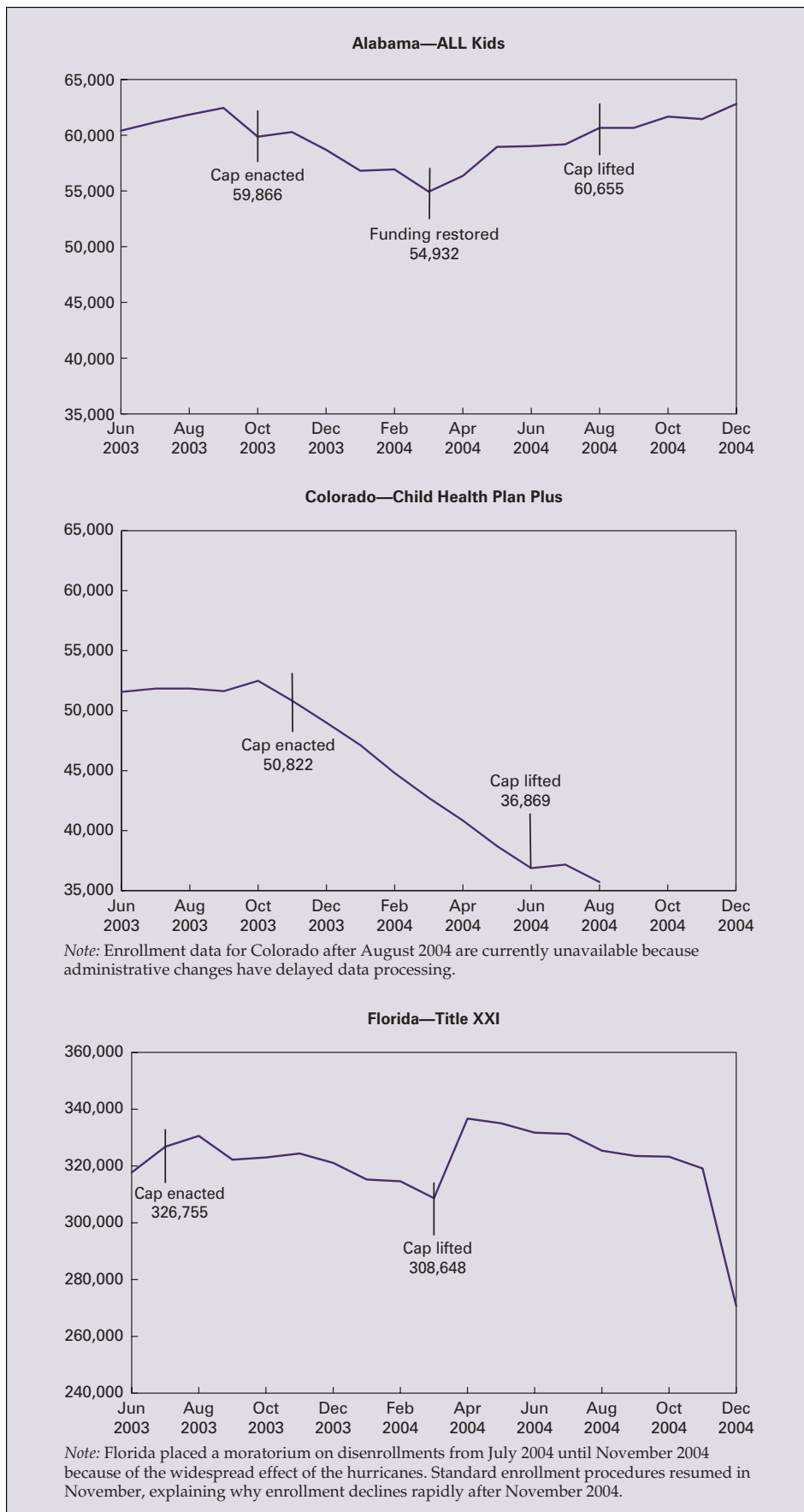
Sources: Kaiser Commission on Medicaid and the Uninsured (2003) ("Program type"); Smith, Rousseau, and O'Malley (2004) ("Children enrolled" 2002 and 2003 and "Change"); Campaign for Tobacco-Free Kids (2002) ("Financing sources").
C = combination; M = Medicaid; S = separate

TABLE 2. State Changes to SCHIP Enacted or Under Consideration in Assessing the New Federalism States in 2004

State	Eligibility/ Enrollment cap	Enrollment process	Outreach	Benefits	Cost sharing	Reimbursement rates	Crowd out
Alabama	+	+	+		+		
California		+			-		
Colorado	+						
Florida	+	-, +		+	-, +		-
Massachusetts		+					
Michigan							
Minnesota						-	
Mississippi		-, +					
New Jersey					-		
New York			-				
Texas							
Washington					-, +		
Wisconsin		+					

Source: Urban Institute telephone interviews with state SCHIP administrators
Key: - = Restrictions enacted
+ = Expansions enacted

FIGURE 1. SCHIP Enrollment Trends during Caps, June 2003–December 2004



eligible applicants from that point on (effectively ending the cap). During the six months that enrollment was restricted, the state’s waiting list peaked at approximately 4,000 children, and total enrollment fell by approximately 7,500 children (12 percent), from 62,450 before the cap was enacted to 54,932.

Colorado. Colorado’s enrollment cap was in place from November 2003 through June 2004. Unlike Alabama, Colorado SCHIP officials did not maintain a waiting list, believing it would be administratively burdensome. As a result, state officials could not gauge the level of unmet demand during the year.¹ Policymakers entered 2004 aiming to lift the cap, and the governor’s budget included full funding for SCHIP. The provision easily passed the legislature and enrollment was reinstated at the beginning of the new fiscal year. During the eight-month freeze, program enrollment dropped nearly 30 percent, from approximately 53,000 to 37,000.

Florida. Florida’s enrollment cap was in place from July 2003 until mid-March 2004. Like Alabama, Florida maintained a waiting list that grew to nearly 91,000 children by January 2004. (An additional 25,000 undocumented children were on a separate waiting list for the state-only funded portion of KidCare.) Because of the state’s “passive” renewal system, Florida suffered proportionately less attrition during the cap, losing roughly 18,000 children (or 5 percent). However, in return for fully funding the enrollment of children on the waiting list, Florida dramatically altered its enrollment and renewal policies, replacing them with new rules that will suppress future enrollment.

Enrollment Procedures

Only two ANF states—Florida and Mississippi—made their enrollment processes more restrictive in 2004. However, these states also took steps to enhance one or more enrollment

procedures, describing these changes as “trade-offs” intended to mitigate the negative impacts of the new restrictions. Four other states also took actions to liberalize certain aspects of enrollment and renewal during 2004 (table 2).

Florida. In return for lifting the state’s enrollment cap, policymakers implemented several restrictions to enrollment policies. First, the state halted continuous open enrollment and moved to a system with open enrollment during specified, time-limited periods. Florida officials expect to have two such “open enrollment” periods a year, neither lasting longer than 30 days. Enrollment will be closed for the rest of the year, and no waiting list of interested families will be maintained. During Florida’s first open enrollment period under this new policy (January 1–31, 2005), the state accepted 96,561 applications. These applications will be processed over three months, and officials estimate they will result in 50,000 to 60,000 new enrollments in KidCare.²

Florida also dropped its policy of allowing families to “self-declare” income and now requires families applying to KidCare to submit documentation. Beginning July 2004, families were required to submit a pay stub, a W-2 wage statement, and a federal income tax return with their applications. In December 2004, however, this requirement was loosened; now families may submit any *one* of these three forms of income documentation (Kaiser Network 2004).³

In addition, Florida revamped its renewal process, moving from its nationally known “passive” system (in which families with enrolled children were automatically renewed as long as premium payments were up-to-date and no income or family circumstances changed) to a more traditional “active” renewal process (Dick et al. 2002; Hill and Westpfahl Lutzky 2003). Under the active system, families are sent renewal notices along with preprinted renewal applications and are asked to verify or update family information and sub-

mit new income verification to continue enrollment.

To offset some potential negative effects of these “cuts,” Florida made two enhancements to its enrollment and renewal procedures. First, the state increased its continuous eligibility period from 6 months to 12, so families will have to complete the new active renewal process half as often. Second, it launched a new renewal assistance program called Pathfinder. Under Pathfinder, families will be mailed reminder notices as their renewal date approaches. Personal phone calls will be placed to those who do not respond to the mail notices. The whole process is supported by a new web site that includes detailed instructions for the various steps families must complete to renew coverage. When Pathfinder was rolled out, KidCare staff went door-to-door in zip codes with the most families that had failed to renew coverage to distribute materials and discuss the program changes face to face.

Florida also placed a moratorium on disenrolling families that were late submitting their renewal packets from July to November 2004 because of the widespread impacts of numerous hurricanes.

Mississippi. The state implemented its Medicaid Reform Act of 2004, which moved the SCHIP and Medicaid eligibility processes from the state’s social services agency to its Medicaid agency and included new requirements for birth documentation. Perhaps more important, the state stopped accepting applications by mail and now requires that families have face-to-face interviews with Medicaid eligibility staff at application and renewal.

To soften the effect of the second change, Mississippi greatly expanded the number of community-based sites across the state where families can meet with eligibility workers to fill out their forms. Families interested in applying for SCHIP will now be able to receive hands-on assistance from workers outstationed at

more than 250 health care and other sites. Before the change, such assistance was only available at 84 county departments of human services. The new approach, according to the state SCHIP director, will hopefully lead to more accurate application submissions while making the program “more community-based.”

Other state changes. Beyond Florida and Mississippi, several other states enhanced their enrollment procedures:

- Alabama introduced a new integrated computer system that will accelerate application processing times and allow families to check the status of their applications by phone. The state also implemented a web-based application in 2004.
- California implemented a new administrative vendor contract in January 2005 designed to improve enrollment processes by increasing the call center’s “call back” requirement (for families needing to renew coverage) from three calls to five; sending families a second written notice and a reenrollment form 30 days after disenrollment, encouraging them to reenroll; providing all web site content in English and Spanish; providing downloadable applications in 11 languages; and enhancing the web-based provider search program to include mapping capabilities and driving directions.
- Massachusetts launched its “virtual gateway,” a web-based application that gives consumers and providers a single point of access to various health and social service programs. Families can use the self-screening function to assess their potential eligibility for various programs, and can download and print program applications from the Internet. For providers, beginning July 2004, the system includes a common intake form that can be completed online (on behalf of families) to create applications for multiple programs.

- Wisconsin developed an online self-screening tool called ACCESS that families can use to determine their potential eligibility for various public programs.

Although Texas made no further cuts in enrollment procedures in 2004, state officials were able to describe the impacts of cuts enacted in 2003 (box 2).

Outreach

Only one state reduced outreach support in 2004, perhaps because the others had little left to cut. New York, after two successive years of outreach expansions, finally reduced funding for its “facilitated enrollment” program.

As our previous briefs reported, SCHIP outreach was one of the first and most extensively cut areas when states began to face budget pressure.

To curb rapid enrollment, most ANF states reduced spending in 2002, and by 2003 all states except Minnesota, New Jersey, and New York had cut most or all of their budgets for media campaigns as well as community-based outreach and application assistance. No ANF state has yet rebounded from the downturn and fully reversed its cuts to outreach.

One ANF state, however, reinstated some of its outreach in 2004. In Alabama, after full funding of ALL Kids permitted the state to lift its enrollment cap, program administrators wanted to tell the public the program had reopened. To this end, the state sponsored radio and television outreach campaigns two months after lifting the cap, and continues to conduct these campaigns statewide.

In addition, other states are considering reinstating various forms of outreach during the next budget cycle. State program administrators

described these reinstatements as efforts to counteract the decreased enrollment from past outreach cuts. Massachusetts spoke of reinstating its “mini-grants” to community-based organizations to conduct outreach; Michigan described a plan for a new mass media campaign; and Washington noted the state is already working on a governor’s initiative—Kids First—that will supply grants to community organizations to perform outreach.

Benefits

SCHIP benefits remained virtually unchanged in 2004 in the ANF states; as program directors explained, leaving coverage intact was a high priority. No state cut benefits, and one—Florida—expanded benefits by raising the annual limit on dental coverage from \$750 to \$800 per child.

In years past, benefits have been perhaps the most protected aspect of the SCHIP program. In 2002, as states began to experience budget pressures, four states actually expanded their benefits packages (Colorado, Florida, Mississippi, and New York), adding coverage for such services as dental care, emergency transportation, and hospice care. In 2003, as states felt more severe pressures, only two ANF states reduced SCHIP benefits—Florida (which placed an annual expenditure cap of \$750 per child on its dental benefit) and Texas (which made more sweeping cuts, eliminating coverage of dental, vision, home health care, and hospice services). Still, two other states continued to broaden benefits in 2003—Alabama (which increased its day limit for substance abuse treatment and liberalized its dental benefits),⁴ and Minnesota (which expanded mental health benefits for at-risk children).

Cost Sharing

Only two states increased cost sharing under SCHIP in 2004, many fewer than did so in 2003. That year, over half the ANF states raised cost shar-

Box 2. The Impact of Enrollment Restrictions in Texas

In 2004, only two ANF states enacted policies to make enrollment procedures more difficult. The previous year, four states took such action. Only Texas officials had assessed the specific impacts of its restriction.

Texas implemented broad cuts in 2003, including changing its method for counting family income (from net income to gross income), effectively lowering its upper income limit; raising premiums for families at all income levels; and eliminating coverage of certain benefits, including dental. The state also changed three enrollment rules; state officials believe that two of these changes are primarily responsible for a precipitous drop in enrollment.

Texas reduced its period of continuous eligibility from 12 months to 6, imposed a new restriction on assets, and required newly enrolled children to wait 90 days before their coverage becomes effective. Following these changes, the state’s SCHIP enrollment dropped from over 507,000 in September 2003 to roughly 358,000 by July 2004, a decline of 149,000 children, or nearly 30 percent. However, because the state delayed implementation of its asset test (until August 2004) and the governor placed a moratorium on disenrolling children for nonpayment of premiums, the enrollment decline is believed to be the combined result of the reduction of continuous eligibility and the 90-day waiting period. Requiring families to renew coverage twice as often has meant that twice as many children as before are disenrolled for not completing the renewal process. The 90-day waiting period, in contrast, has markedly reduced the number of children entering the program to offset disenrollment.

Enrollment is expected to continue dropping as the effects of the new assets test (implemented August 2004) become clear and as the moratorium on disenrolling families for nonpayment of premiums is lifted.

ing for enrollees, a development notable not only because no states had raised premiums or copayments in 2002, but also because of the magnitude of some increases. For example, Wisconsin raised its premium from 3 percent of family income—already the highest in the nation—to 5 percent, the maximum allowed under federal law. Texas enacted a new \$15-a-month premium on families with earnings between 101 and 150 percent of the federal poverty level (FPL); previously, these families had to pay only \$15 a year. While such changes were likely to affect enrollment and retention rates, no states were able to report such impacts.

Specific changes in 2004 included the following:

- California enacted the first premium increase in the history of its Healthy Families program in 2004. The hike will take effect in July 2005 and will add \$6 per child per month to the premium paid by families earning incomes between 200 and 250 percent of FPL. (Previously, all families earning between 150 and 250 percent of FPL paid the same monthly premiums—\$6 or \$9 per child, depending on the plan chosen by the family.)
- New Jersey raised its monthly premiums for families at all income levels by the same percentage for the second straight year. The effect of this year's hike ranged from a small \$0.50 monthly increase for families with incomes between 151 and 200 percent of FPL (upon a base premium of \$16.50 per family) to a \$3.50 monthly increase for families earning between 300 and 350 percent of FPL (upon a base premium of \$110 per family). Enrollees can expect to see regular increases like these in the future; the state amended its SCHIP plan to include annual premium increases indexed to the federal poverty level.

- Florida increased the time families are “locked out” of program participation for missing a premium payment to six months. This more restrictive policy was only in effect for six months, however, from January to July 2004. It was then reversed and the original lock-out period of two months was reinstated.
- Washington, effective August 2004, increased monthly premiums from \$10 to \$15 per child for families with income between 200 and 250 percent of FPL and raised the family maximum for premiums from \$30 to \$45 a month. The state also reduced the number of consecutive months a client can be in arrears on paying premiums from four months to three.

Two states enacted policies that liberalized cost sharing rules for families in 2004. Florida rolled back its 2003 premium increase (from \$20 to \$15 per month) for its lowest-income families (those earning between 100 and 150 percent of FPL), because federal officials deemed the increase exceeded federal upper limits. Washington reduced its “lock-out” period for families disenrolled for nonpayment of premiums from four months to three.

Several other states were considering or planning to implement similar enhancements, including Mississippi (eliminating its six-month “lock-out” period), Alabama (allowing families to pay premiums with credit cards), and New York (offering discounted premiums to families who prepay several months, as well as multiple methods for making payments).

Provider Reimbursement

For 2004, provider reimbursement remained largely unchanged. Only one state—Minnesota—cut its inpatient hospital reimbursement rate by 5 percent and its pharmacy reimbursement rates from \$9 to \$11 below average wholesale price.

Unlike their Medicaid counterparts, SCHIP programs have rarely reduced provider reimbursement, even in the face of growing and ongoing budget pressure. In 2003, however, one state froze rates for participating health plans (California) and three reduced rates by 3 percent or less (Massachusetts, Texas, and Washington).

Crowd Out

Over the three years we have conducted this survey, few ANF states have altered their “crowd out” policies in response to budget pressures. The year 2004 was no exception: Only one state enacted a change intended to discourage substituting public health insurance for private coverage. Florida added three new questions about health insurance availability to its SCHIP application. The new questions inquire whether parents have access to employer-sponsored coverage for children and, if so, the cost of that coverage. For parents whose employers offer dependent coverage that would cost less than 5 percent of family income, Florida denies their children's eligibility for the subsidized Healthy Kids program, but gives parents the option to buy into the program at the unsubsidized rate of \$110 per child per month. State officials have analyzed the state's employer market and their own enrollment files and have determined that this policy will likely affect less than 1 percent of the families enrolled in Healthy Kids.

Wisconsin enacted a similar policy in 2003 that required employed parents to provide written documentation that they did *not* have an offer of health insurance at their place of employment before enrolling them or their children in BadgerCare.⁵ The state implemented this policy in May 2004 and witnessed a significant drop in enrollment in the months that followed—over 18 percent by December 2004. State officials are uncertain about how much of this disenrollment is the result of the policy change

and how much might be attributable to the premium increase passed the same year. Wisconsin is currently studying the causes of disenrollment.

The ANF States Compared to the Nation

The ANF states seemed more active than states overall in 2004, cutting and enhancing their programs. For example, while 2 of the 13 ANF states enacted restrictions to their enrollment procedures, none of the other 37 states or the District of Columbia made such changes to their SCHIP programs in 2004. While 4 of the 13 ANF states raised premiums in 2004, only 2 other states did so nationally.⁶ And only one other state—Georgia—tightened its crowd-out prevention policies by increasing its waiting period (that children are required to be uninsured before enrolling in SCHIP) from three months to six (Cohen Ross and Cox 2004).⁷

Regarding eligibility, Maryland lifted its enrollment cap within a year of enactment, just as all three ANF states with caps did. Montana, however, maintains a cap but permits children to enroll off its waiting list each month as slots open. And Utah maintains a system like Florida's, holding "open enrollment" periods twice a year.⁸ The only other state that changed its eligibility policy in 2004 was Idaho, which created a new expansion group—children in families earning between 150 and 185 percent of FPL—that is subject to an enrollment cap.

Conclusions and Outlook

Reflecting the evolving economies in the states—which were described as improving but still stressed—SCHIP programs are in a holding pattern of sorts. Overall, states made far fewer cuts in 2004 than in 2003, and officials continue to report that SCHIP is highly valued by policymakers, providers, and consumers. That value apparently drove several states to use the same flexibility that had been used in 2003 to clamp down on program growth to reverse those cuts in 2004. Most notably, every ANF state that imposed an enrollment cap in 2003 did away with it in 2004.

Many states also continued to simplify enrollment procedures and others enacted policies to make it easier, logistically, for families to comply with cost sharing requirements.

However, the lack of activity in 2004 also had a downside. The year saw virtually no improvement in outreach, thus dimming SCHIP's prospects for further reducing the rate of uninsurance among children in the coming year. Further, states like Texas did nothing to reverse the raft of changes made in 2003 that cut eligibility and benefits, raised cost sharing, and made enrollment more challenging.⁹ Wisconsin maintained its highest-in-the-nation premium, even in the face of declining enrollment. And Florida, despite lifting its enrollment cap, restricted future growth by closing enrollment except during two 30-day "open" periods each year, while requiring families to play a more active role in eligibility renewal.

Looking back over the past three years, it is possible to observe net gains, and net losses, in various SCHIP policies (table 3). Eligibility criteria have remained stable; Texas is the only ANF state with an income limit that is lower today than it was in 2002. Over the three years, as many states enhanced enrollment procedures as imposed new restrictions. Benefit expansions have outnumbered cuts overall, while freezes and modest reductions in reimbursement have occurred in less than half of the study states.

The two policy areas where net reductions are noteworthy, however, are cost sharing and outreach. In the case of the former, 7 of the 13 ANF states raised existing premiums or imposed new ones—policies still in place in 2005. At the same time, these increases have been modest, except in Wisconsin and Texas. In the case of outreach there is no ambiguity—SCHIP outreach has for all intents and purposes ceased to exist. Evidently, states have decided that programs cannot sustain the growth rates of SCHIP's first four years during an economic downturn. Outreach has been scaled back or eliminated in an effort to curtail growth. It has been suggested, therefore, that the federal government may need to play a greater role in financing care if SCHIP is to be relied

TABLE 3. SCHIP Policy Changes in Assessing the New Federalism States, 2002–2004

POLICY CHANGES	AL		CA		CO		FL		MA		MI		MN		MS		NJ		NY		TX		WA		WI			
	02	03	04	02	03	04	02	03	04	02	03	04	02	03	04	02	03	04	02	03	04	02	03	04	02	03	04	
Eligibility																												
Income limit																												
Enrollment cap																												
Waiting period ^a																												
Enrollment Procedures																												
Continuous eligibility																												
Presumptive eligibility ^b																												
Assets test																												
Face-to-face interview																												
Limited enrollment period																												
Documentation																												
Online/New application design																												
Outstanding eligibility workers																												
Renewal																												
Outreach																												
Media																												
Community-based																												
Benefits																												
Coverage																												
Limits																												
Cost Sharing																												
Premium																												
Copayments																												
Payment policies																												
Reimbursement																												
Rates																												
Crowd Out																												
Waiting period																												
Questions on application																												

Source: Urban Institute telephone interviews with state SCHIP administrators.

Key: - = Restrictions enacted + = Enhancements enacted

Shading indicates years enacted policies were in place.

a. In 2003, Texas imposed a 90-day waiting period before program benefits become effective for new enrollees.

b. For California, these enhancements refer to the state's "CHDP Gateway" and "Express Lane Eligibility" enrollment initiatives.

upon to provide a coverage safety net during such downturns (Dubay and Kenney 2004).

Looking ahead, the future course for SCHIP is uncertain. In 2004, 36 states spent more than 100 percent of their annual allotments. Yet that same year, for the first time, unspent federal funds in the amount of \$1.3 billion reverted to the treasury. Federal funds available for redistribution are expected to fall in the coming years while the number of states needing redistributions is expected to rise (Mann and Rudowitz 2005). The only current prospect for enhanced federal funding for SCHIP has been proposed in the Bush administration's "Covering the Kids" outreach initiative. However, when we asked SCHIP directors what they thought of this proposal, they expressed appreciation tempered by strong trepidation. That is, federal support for outreach would be welcomed by the states, but only if allotments were increased as well to cover the services new enrollees would need.¹⁰ SCHIP already faces excess demand for coverage. Providing new funding for outreach, without supporting states' ability to supply additional coverage, would only exacerbate the program's financing challenge.

Notes

1. However, Colorado's Covering Kids and Families grantee worked with community-based organizations across the state to tally the number of families that attempted to apply for SCHIP during the cap and estimated that roughly 6,000 had done so.
2. At the time of this writing, Florida legislators were considering a bill that would once again allow children to enroll in KidCare throughout the year (Jim Saunders, "Plan Calls for Open KidCare Sign-Up," *Daytona Beach News-Journal*, April 7, 2005).
3. *Tallahassee Democrat*, "House Readies Bill Easing KidCare Requirements," December 16, 2004.
4. The state no longer counts the cost of preventive dental care against a child's \$1,000 annual cap.
5. For those families with an offer of employer-sponsored coverage, state officials investigate whether it is more cost-effective to subsidize that coverage or enroll the family into direct coverage under BadgerCare.
6. Arizona began requiring its families earning 100–150 percent of FPL to pay monthly premiums and raised the amounts that families earning 150–200 percent of FPL must pay. Missouri raised premiums for families earning 225–300 percent of FPL (Cohen Ross and Cox 2004).
7. Cohen Ross and Cox did not report on changes in outreach, benefits, and provider reimbursement.
8. Beginning in state fiscal year 2006, Utah will permit year-round open enrollment.
9. Because Texas operates under a biennial budget cycle, the legislature did not meet during 2004. Reversing some of Texas's 2003 cuts is reportedly a high priority among many Democratic lawmakers heading into the 2005 session.
10. Of course, outreach funding is of no use to states with closed enrollment much of the year, like Florida and Utah.

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